**Implanon® use in overweight clients**

In reference to the letters from Drs Barber and Waters1 and Dr Matiluko 2 in regards to the earlier replacement of Implanon in heavier women, the FFPRCG Guidance is that weight does not have an effect on the efficacy of Implanon. It would be a shame if women over 70 kg were subject to an unnecessary change of Implanon at 2 years because of these letters, and it will also impact on an already overstretched drug budget.

Dr Matiluko in his reply3 suggests that women resuming bleeding after a period of amenorrhea on Implanon should seek advice about earlier replacement. The CEU recommends following UKMEC Selected Practice Recommendations for Contraceptive Use, namely that women developing bleeding should be investigated if clinically indicated and that the serum concentrations of Implanon remain sufficient to inhibit ovulation throughout the 3 years and a return to bleeding does not demonstrate a return to fertility.5

**Reply**

Whilst we would agree with current advice regarding Implanon® replacement, many clinicians err on the side of caution if regular menses have recurred or bleeding pattern is unacceptable, so we cannot agree with the implication that particularly if the weight is >100 kg, whilst not being concerned at weights of 70–100 kg. The point of our response was to extrapolate this circumstance and use it as a model for women receiving enzyme-inducing or -inhibiting medication as part of combined antiretroviral therapy, who may have presumed reduced contraceptive efficacy. Although firm evidence is awaited and Implanon is not currently recommended in this group, the fact remains that it is an attractive form of contraception for our HIV-infected cohort and we must be able to give best opinion to patients who use this method as to how most safely to proceed. The number of HIV-infected women using this method, to our knowledge, remains low. Depo-Provera® or IUD/ IUS plus barrier contraception (condoms) remain more suitable. It was not our intention for this extrapolation to contravene Faculty advice about the use of Implanon in women >70 kg where we agree early replacement may be unnecessary both for the patient and in terms of expenditure.


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**Risk assessment documentation in COC prescribing**

Documentation is important in the ever expanding defensive medicine culture, particularly when prescribing medication. As a female Foundation 2 Doctor in General Practice, I see many women appropriate contraceptive pill checks. I was surprised to find that very few consultations documented a risk assessment when the pill was first prescribed, considering factors that are very clearly outlined in the British National Formulary (BNF). In response to this observation I audited the initial consultations of combined oral contraceptive pill (COC) prescribed to review the documentation of a risk assessment in general practice. The audit served to quantify the standard of medical record keeping and act as a pointer of the risk involved in prescribing the COC. A total of 325 consultations have been taken to improve record keeping in this area, and in turn improve clinical care. Consequently I feel this is an interesting and relevant topic for discussion.

Recording a full risk assessment prior to prescribing the COC is difficult within the time constraints of general practice. However, before prescribing a hormonal method of contraception it is the clinician’s responsibility to determine and record any contraindications to use in the individual. Clear guidelines exist for prescribing the COC in the BNF1 and World Health Organization Medical Eligibility Criteria (WHOMEC)2 and in particular, recognise a risk among women with a personal or family history (FH) of venous thromboembolism (VTE).3

An audit carried out in a surgery in North Devon to review the documentation of risk assessment in the first issue of the COC demonstrated poor performance in this area. Of the 134 women audited, only 4% of consultations documented specifically ‘no FH of VTE’, and 14% included a broad statement like ‘no contraindications’. The remaining 82% of consultations made no mention of a risk assessment. A personal negative history of FH was recorded in 1% of consultations and a further 21% made a general comment with reference to past medical history. The BNF parameters of height, weight body mass index, smoking status and blood pressure were only completed in 24% of consultations and only 3% included all of these five parameters and had a broad statement regarding ‘no contraindications’. No consultations included a specific statement about VTE risk, personal or within the family, and all of these parameters.

With the increasing emphasis on defensive medicine, documentation needs to be improved to protect the practitioner and demonstrate the patient gave fully informed consent. In cases where clear guidelines exist on prescribing, general practitioners should ensure their computer templates offer relevant prompts for questioning to allow rapid, complete documentation of the consultation. Ultimately it is the responsibility of the prescriber to ensure that risks do not outweigh the benefits and, if in doubt, consider alternatives.

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Author’s note

The text of this letter is taken from a poster presentation by the author at the Medical Woman’s Federation’s 90 Years and Beyond’ Conference on 1 November 2007 at the Royal College of Obstetricians and Gynaecologists, London, UK.

**References**


**LETTERS TO THE EDITOR**

Letters to the Editor are welcome and generally should not exceed 600 words or cite more than five references. For comments on material published in the most recent issue of the Journal, correspondence should be received within 4 weeks of dispatch of that Journal to be in time for inclusion in the next issue. When submitting letters correspondents should include their job title, a maximum of two qualifications and their address(es). A statement on competing interests should also be submitted for all letters. Letters may be submitted to the Editor or the Journal Editorial Office (details on page 73).
Implanon® use in overweight clients

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